

# NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

## PERSONAL

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
SEX:  MALE  FEMALE  
MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  
 WIDOWED  SEPARATED  
REFERRING PHYSICIAN: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
JOB TITLE: \_\_\_\_\_  
PHYSICIAN TO BE SEEN: \_\_\_\_\_

## TELEPHONE

WHERE DO YOU PREFER TO RECEIVE PHONE CALLS?  
 HOME  
 WORK  
 OTHER: \_\_\_\_\_  
MOBILE/PAGE #: \_\_\_\_\_  
WHEN IS THE BEST TIME TO BE REACHED?  
DAY: \_\_\_\_\_ TIME(S): \_\_\_\_\_

## EMERGENCY

PERSON TO CONTACT IN CASE OF EMERGENCY:  
NAME: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_  
WHEN IS THE BEST TIME TO BE REACHED?  
DAY: \_\_\_\_\_ TIME(S): \_\_\_\_\_

## PRIMARY INSURANCE

COMPANY NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
NAME OF INSURED: \_\_\_\_\_  
POLICY/ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OCCUPATION: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
DATE EMPLOYED: \_\_\_\_\_  
DEDUCTIBLE: \$ \_\_\_\_\_  
CO-PAY AMOUNT: \$ \_\_\_\_\_

## SECONDARY INSURANCE

COMPANY NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
NAME OF INSURED: \_\_\_\_\_  
POLICY/ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

OCCUPATION: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
DATE EMPLOYED: \_\_\_\_\_  
DEDUCTIBLE: \$ \_\_\_\_\_  
CO-PAY AMOUNT: \$ \_\_\_\_\_

## BILLING INFORMATION

NAME OF PERSON RESPONSIBLE FOR SERVICES NOT COVERED BY  
INSURANCE COMPANY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ EXT: \_\_\_\_\_  
MOBILE/PAGE: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_

*For your convenience, we offer the following methods of payment.  
Please check which option you prefer.*

- CASH  
 PERSONAL CHECK

I hereby authorize you to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician or physician group. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient/Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.